General Practice Indemnity

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NHS Resolution Services

NHS Resolution

Claims Management

Delivers expertise in handling both clinical and non-clinical claims through our indemnity schemes.

Primary Care Appeals

Offers a quasi-tribunal service for the fair handling of primary care contracting disputes.

Practitioner Performance Advice

Provides advice, support and interventions in relation to concerns about the individual performance of doctors, dentists and pharmacists.

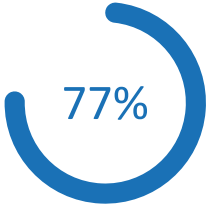
Safety and Learning

Supports the NHS to better understand their claims risk profiles, to target their safety activity while sharing learning across the system.

Enabled by:

- Finance and Corporate Planning
- Digital, Data and Technology
- Membership and Stakeholder Engagement
- Policy, Strategy and Transformation

Year in review - claims



A record 77% of claims were settled in 2021/22 without court proceedings, up from 75% last year

16,484 clinical and non-clinical claims were settled in 2021/22 compared with 15,712 in 2020/21

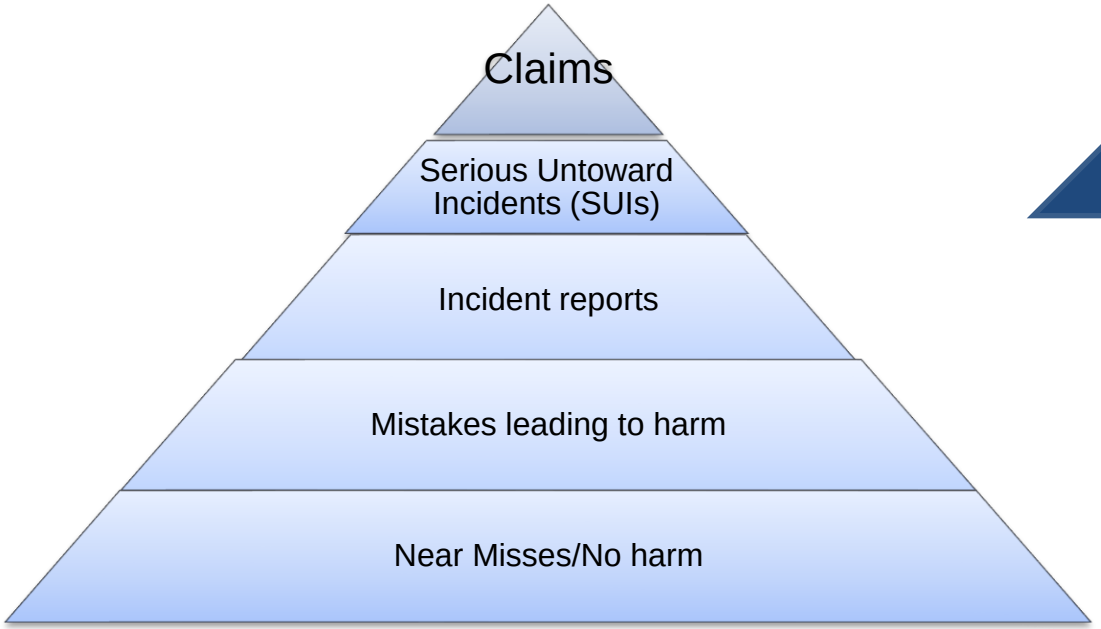
Nearly £2.5 billion was paid out on 17,539 closed clinical and non-clinical claims in 2021/22

12,623 claims were settled without proceedings in 2021/22, compared with 11,738 in 2020/21

This year the ‘annual cost of harm’ is £13.3 billion across CNST

The volume of clinical negligence claims and reported incidents received in-year increased from 13,351 to 15,078

Claims: The tip of the iceberg



The opportunity to reduce harm and improve safety is the way that the near miss and no harm incidents are handled.

General practice indemnity

Read more about our general practice indemnity schemes here:

Clinical Negligence Scheme for General Practice (CNSGP)

Existing Liabilities Scheme for General Practice (ELSGP)

CNSGP

Clinical negligence — an act, or an omission to act in connection with the diagnosis of an illness or the provision of care or treatment which results in personal injury or loss

for

"Eligible persons"

- Contract holder (GP Partner)
- Employee
- "otherwise engaged"
- Sub-contractor

doing

"Relevant functions"

- General Medical Services (GMS)/Primary Medical Services (PMS)/ Alternative Provider of Medical Services (APMS)
- Other NHS work

Therefore not:

- Professional cover
- Private work
- Secondary care by NHS trusts

The benefits of CNSGP

Bringing clinical indemnity cover for all NHS activities in England under one roof. For the first time, one organisation will have access to the learning from all NHS clinical negligence claims and what can be done in a consistent way to reduce claims and improve patient safety.

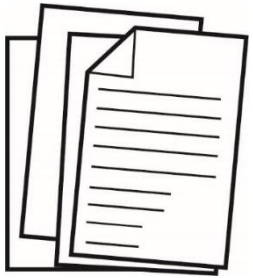
- CNSGP is centrally funded, meaning that those working in general practice do not need to make any payments to benefit from the scheme.
- Cover is automatic, there is no need to register or apply to the scheme.
- Scheme provides cover on an occurrence based arrangement.

Clinical Negligence Scheme for General Practice - NHS Resolution

CNSGP documents

In agreement with the Department of Health and Social Care we have published a range of documentation with guidance on:

- The scheme rules (and a short guide)
- When and how to report a (potential) claim
- Responding to complaints
- How long patients have to bring a claim
- What happens when a claim is brought
- Scheme scope [Scheme scope - NHS Resolution]
- Disclosing records

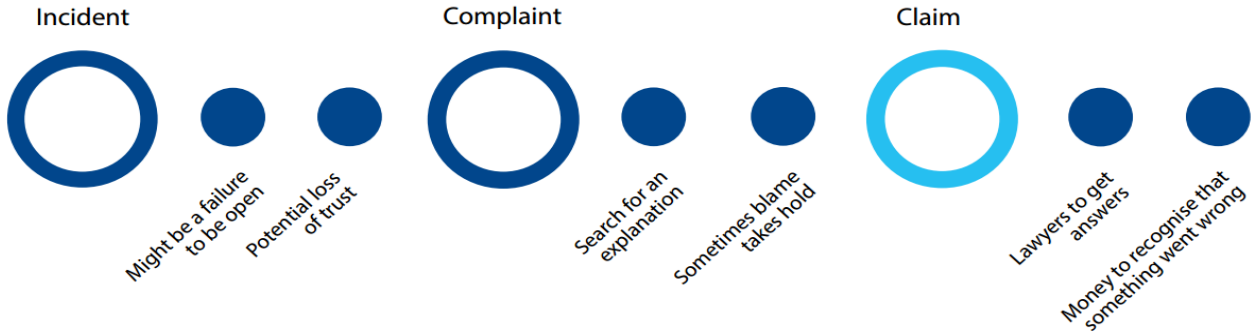


Please visit https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-general-practice/

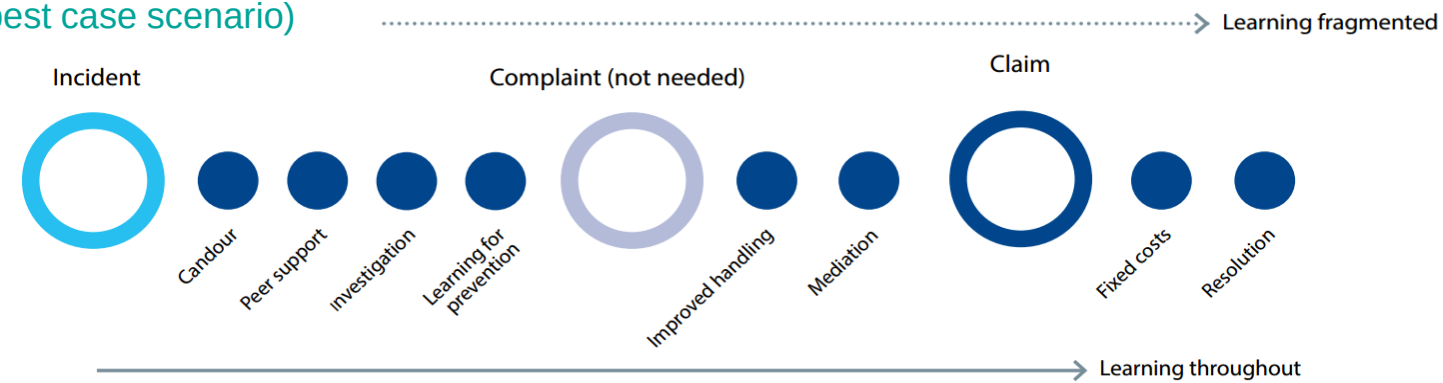
Our role – moving upstream to reduce harm

NHS Resolution

Current (worst case scenario)

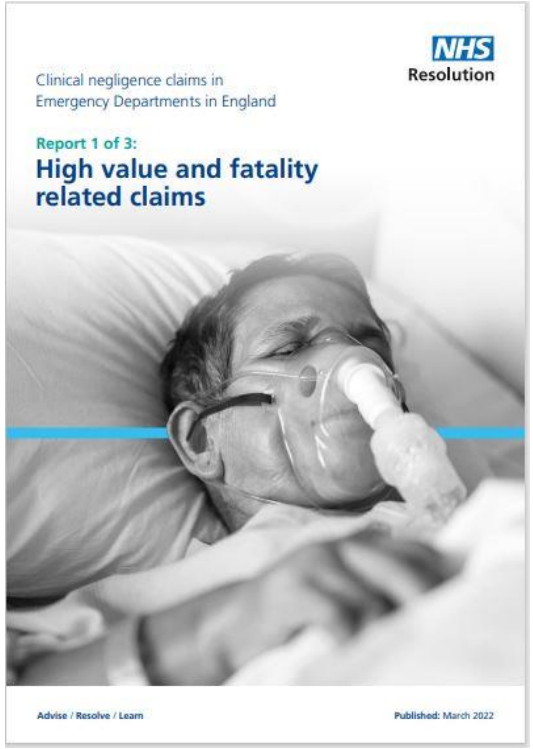


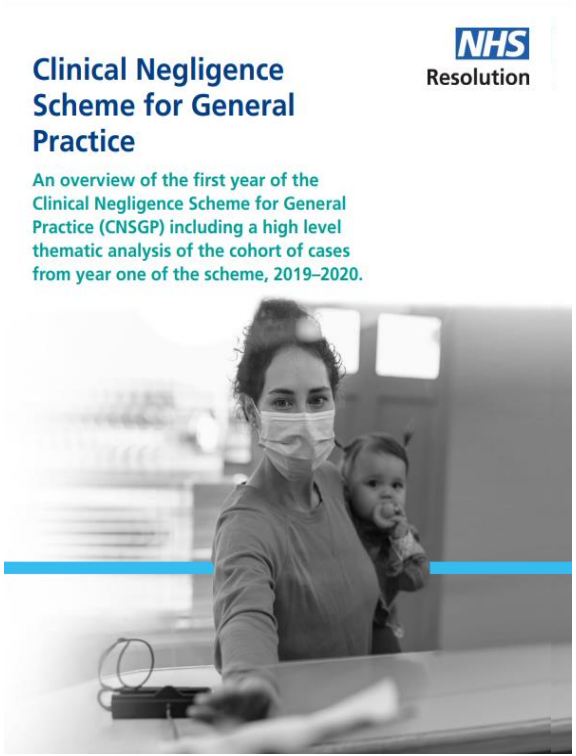
Future (best case scenario)

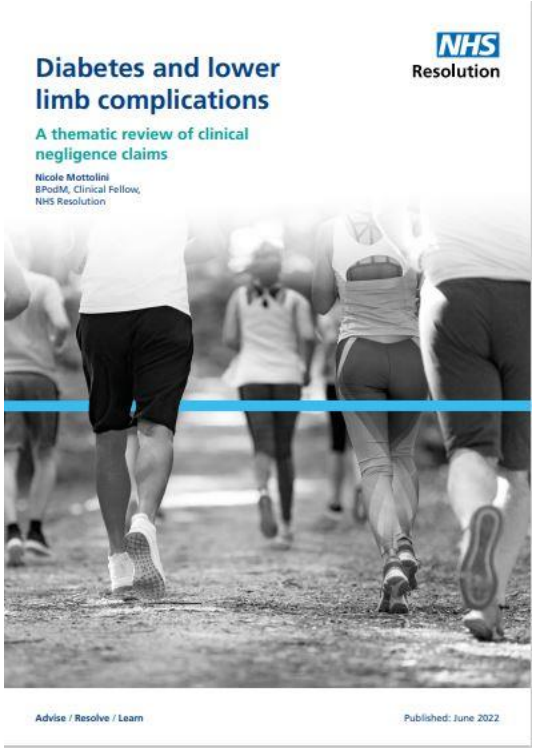


Thematic reports

NHS Resolution







Common themes

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Failures in the investigation process leading to missed or delayed diagnosis

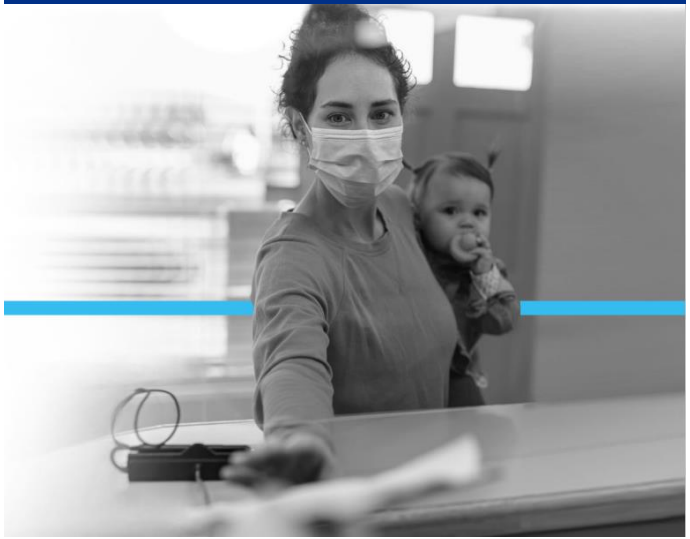
Diagnostic errors including missing signs of deterioration

Failure to recognise the significance of re-attendance

Communication issues impacting the escalation and handover of care and cross specialty team working

CNSGP Year One Report 2019-2020

Clinical Negligence Scheme for General Practice
Read the full report by clicking on the image:



The most frequent common case notifications were for

- Cancer (37, 9.3%),
- Cardiac (29, 7.3%)
- Sepsis (21, 5.3%)

One year's worth of data only provides an indication of the cases NHS Resolution may expect to see in the coming years and no firm conclusions can be drawn from the first year's data

CNSGP claims

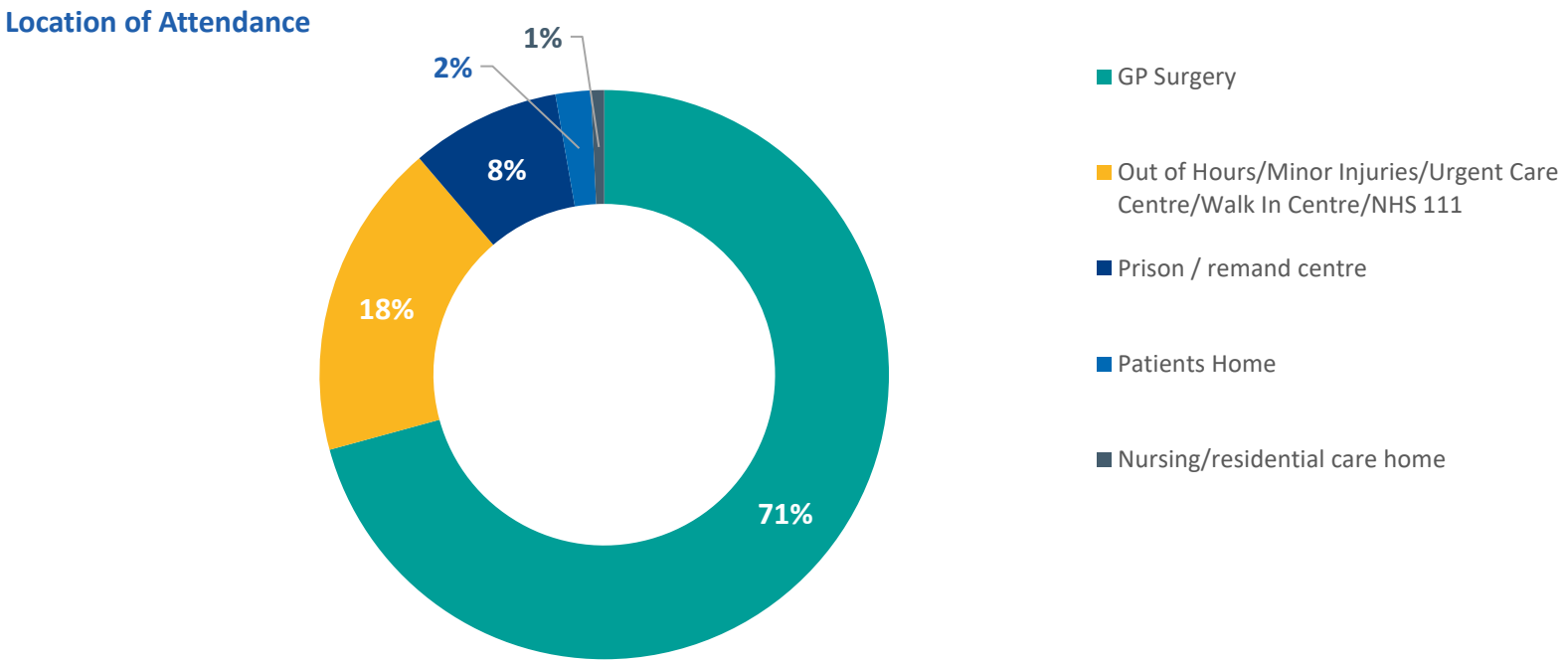
11,682 total claims (2019/20)

401 GP claims

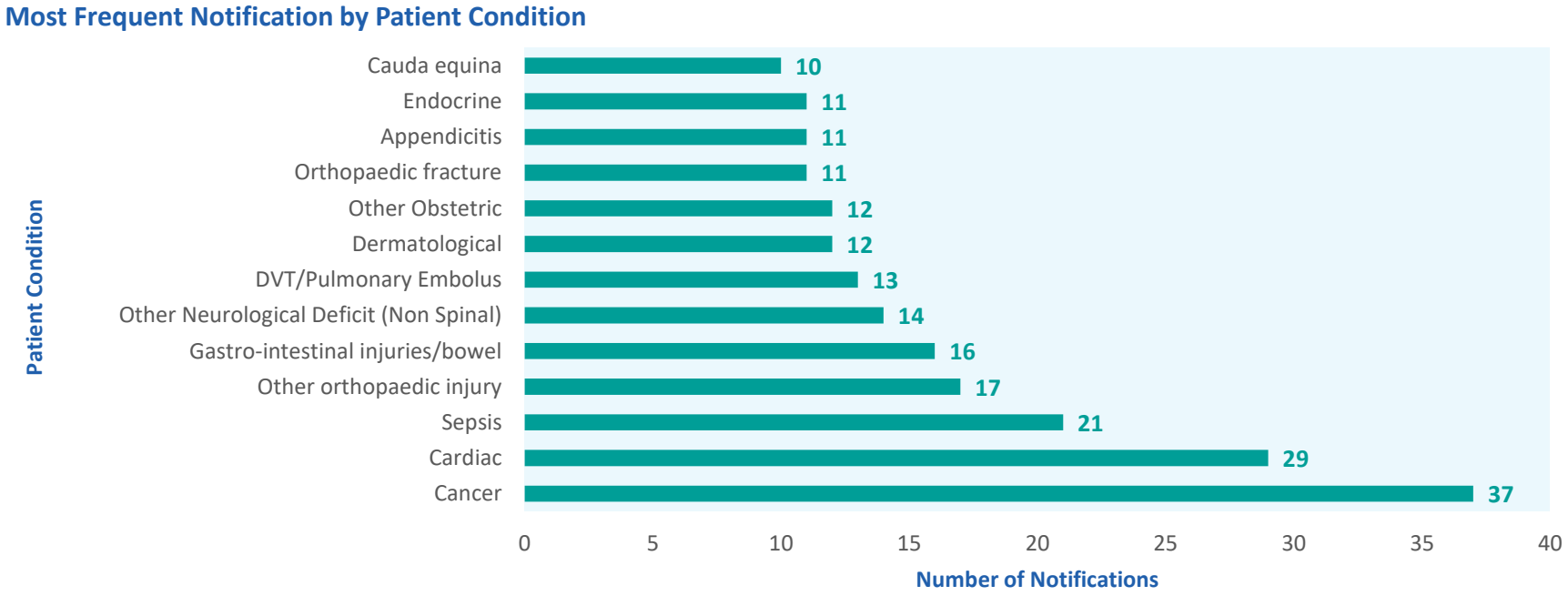
Common Themes:

1. Failure to investigate and/or diagnose, and missed, wrong and delayed diagnoses
2. Medication errors
3. Delays in care, including specialty reviews and referrals
4. Problems with communication, between primary and secondary care

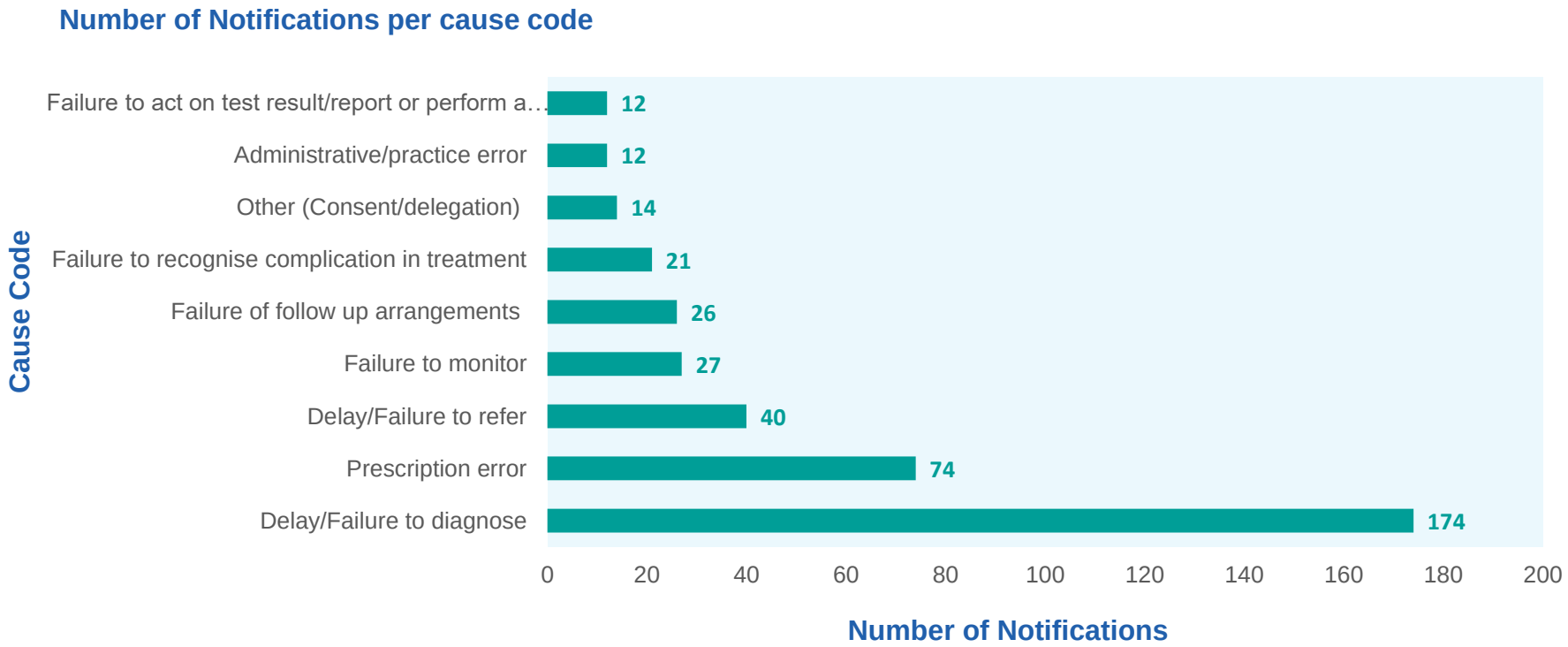
Location of Attendance



Most Frequent Notifications by Patient Condition



CNSGP notification causes



CNSGP Report Recommendations

1. Recommend NHS England, the Royal Colleges, Getting It Right First Time and Professional Regulators work together to explore the feasibility of a patient acuity risk (track and trigger system[2]) assessment tool for use in general practice to assist earlier identification of deteriorating patients

2. Recommend that NHSX with NHS Digital GP IT[3] (see footnote) and NHS England continue to promote existing safety netting tools (including minimizing inequalities e.g. enhancing easy reading, translation and digital exclusion) such that they are available nationally.

3. Recommend that policy makers, academic partners and NHS bodies explore feasibility of further development of advice and guidance service that enables improved communication and collaboration between general practice and secondary care.

4. Recommend that NHS bodies, Royal Colleges and associated stakeholders consider collaboration to support introduction of Protected Learning Time across general practice teams.

[2] Guidance | Acutely ill adults in hospital: recognising and responding to deterioration | Guidance | NICE
[3] NHS England have now created a Transformation Directorate, incorporating NHSX and NHS Digital

Recommendations (continued)

NHS Resolution

5. • Recommend that professional regulators consider using the Royal Pharmaceutical Society (RPS) competency framework as a benchmark when reviewing prescribers and prescribing in conjunction with National Institute of Clinical Excellence (NICE) guidance on medications management.

6. • Recommend that NHSX, as part of its Digital Clinical Safety Strategy, consider research into why clinicians override adverse drug reaction system prompts and how this may be minimised.

7. • Recommend that NHS England suggest Integrated Care Systems appoint a Designated Medication Safety Officer supporting clinicians in adhering to the Green Book recommendations on the handling and storage of vaccines and to share any learning from error.

8. • Recommend that commissioners, providers and Integrated Care Systems who oversee prison services, consider increasing the use of the telemedicine across the estate working to support primary and secondary care appointments as well as improving continuity of care with community services.

GP Indemnity medication claims *(data set 2015-2020)*

NHS Resolution

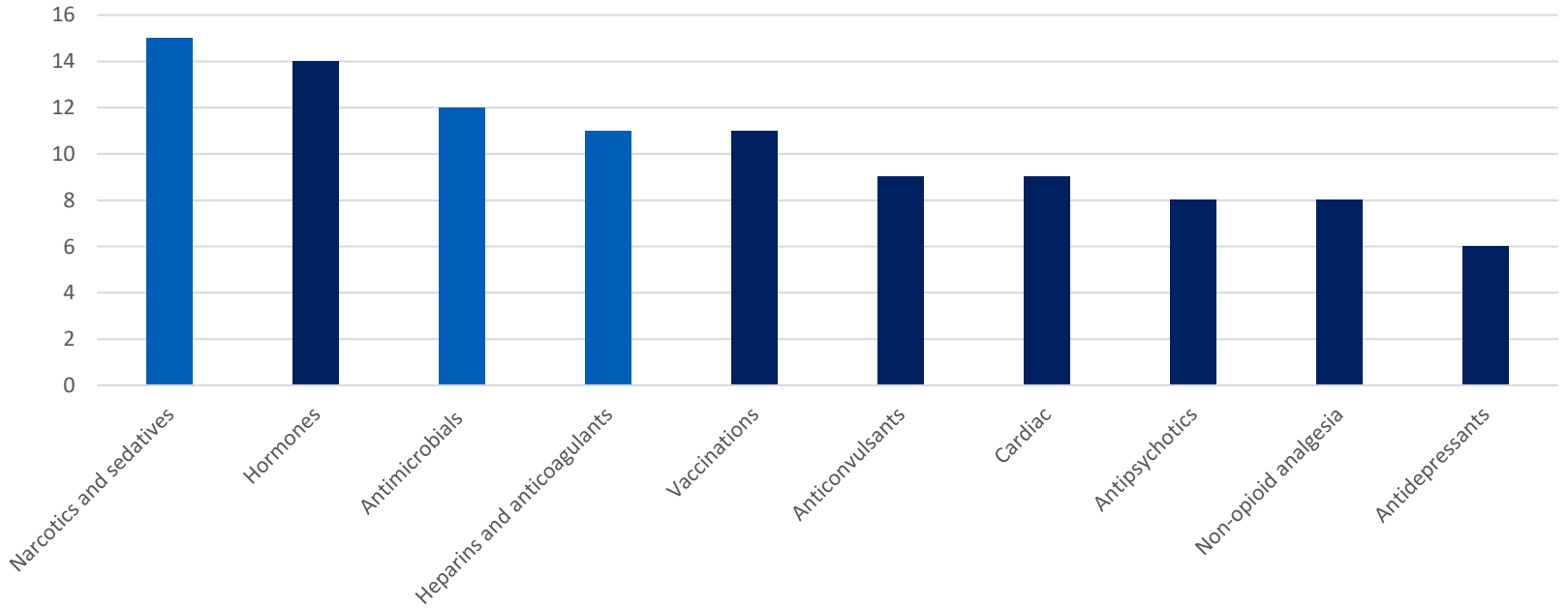
128 claims

Total costs = £8,908,004

Total Damages = £6,982,636

- 54 open claims
- 45 unmeritorious claims
- 11 claims settled with damages paid

Drug class – GP Indemnity Schemes



Illustrative Case Story

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Situation

A 64-year-old woman with multiple health care visits for various subjective complaints including oesophageal reflux, urgency of micturition, urinary tract infections and hypertension.

Background

The patient had a history of recurrent urinary-tract infections and visited their general practice.
They were prescribed a treatment dose of Nitrofurantoin for five days followed by a prophylactic dose for 28 days.

This course was repeated over a period of two years.

Communication:

- Healthcare professionals reminded of the risks using nitrofurantoin in patients with renal impairment, MHRA's Drug Safety Update.
- Nitrofurantoin's use increased since guidelines repositioned it as first-line therapy for uncomplicated lower urinary tract infection. https://academic.oup.com/jac/article/70/9/2456/721364)

Assessment

After onset of gradual onset of breathless and practice based investigations, peak flow monitoring, spirometry, CXR

The patient was eventually referred to secondary care with symptoms of breathlessness of unknown aetiology

A CT Scan was organised and the patient was eventually diagnosed with **Nitrofurantoin-induced interstitial lung disease (NIILD)**

The practice noted that they had failed to make the connection between Nitrofurantoin prophylaxis and a rare lung condition. The medication was discontinued, an apology was given to the patient and a significant event with actions implemented to improve patient safety

Recommendation

NHS Resolution recommendation to raise awareness of this antibiotic side effect and the need to advise patients of potential side effects.

Nitrofurantoin is commonly used to treat **urinary-tract infections.** It is usually well tolerated

Nitrofurantoin-induced interstitial lung disease (NIILD) is seen in <1% of patients. Most cases are reversible, and the overall mortality is 1.19%.

Nitrofurantoin induced interstitial lung disease - PMC (nih.gov)

Drug-Induced Interstitial Lung Disease from a Misdiagnosed Infection - PMC (nih.gov)

Infectious Diseases Society of America guidelines for the diagnosis and treatment of asymptomatic bacteriuria in adults - PubMed (nih.gov)

Illustrative claims example: safety netting

- Young child <3 years
- Presented with eating and drinking very little, not talking
- Patient assessed for upper respiratory infection, no other symptoms
- Prescribed penicillin and paracetamol.

- 2 days later patient presented at hospital with MRI showing hydrocephalus – and suffered permanent neurological damage
- Documentation only stated – if symptoms worsen or persist see own GP for review
- No other advice recorded

Did you know? Medication errors

Click on any of the pictures to read the full leaflet.

You can find other some of our other products for learning via our website here.

Did you know? Insights into medication errors

Did you know? Anti-infective medication errors

Did you know? Heparin and anticoagulants

Did you know? General Practice Medication Errors

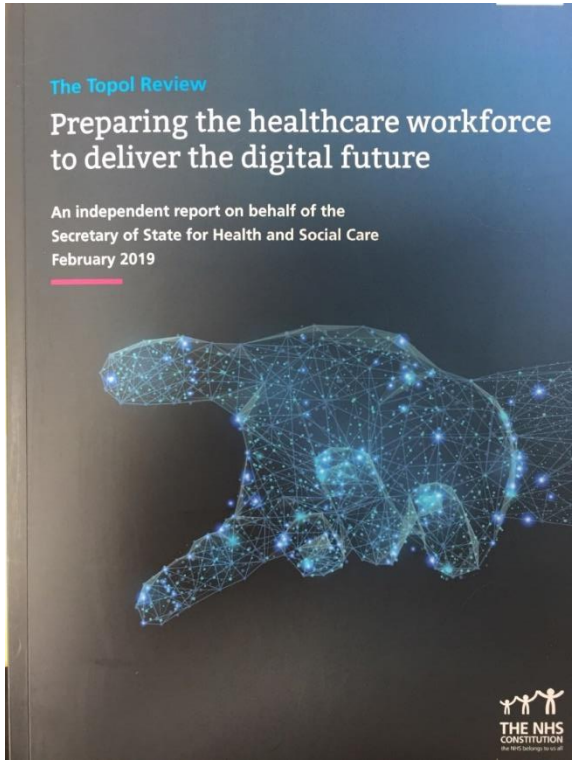
Did you know? Maternity Medication Errors

Did you know? Extravasation

Impact of Covid-19

- We have forecast £1 billion in our provision for Covid-19 related claims compared to a net impact of Covid-19 of £0.5 billion across all schemes last year.
- The main driver of the increase is the higher number of assumed claims in relation to the indirect impacts of Covid-19 of delays, cancellations and misdiagnosis reflecting longer waiting lists.
- To date, the number of claims received related to Covid-19 under CNSC, are comparatively small.

Covid-19



Prior to Covid-19 the Topol review discussed ways of delivering a digital future

Covid-19 has accelerated this process of change

Teleconsulting: benefits / threats / opportunities

NHS Resolution

Rapid expansion of tools / resources to cope better with Covid-19

- Reduce pressure on inpatient care and protect resources
- Reduce viral transmission by reducing contacts
- Accessibility
- Ongoing care – remote support

For benefits to be realised, We need:

- Training and support for health professionals to build rapport with patients remotely
- Evaluation of the strengths and limitations of remote consultations
- Consider when it is most appropriate? Not for patients with complex needs or when lack of trust exists
- Consider how to prevent/minimise the 'digital divide'

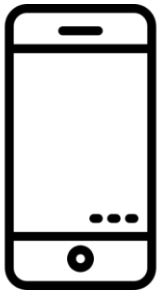
Richardson *et al*, 2020, 'Keeping what works: remote consultations during the Covid-19 pandemic', *Eurohealth,* 2020; 26 (2)

Clinician concerns

- I don’t feel confident using the technology… I’ve never had any training!
- Phone and video consultations take a lot of my time and energy…
- What do I need to cover in order to gain patient consent for having a teleconsultation?
- I don’t find it so easy to build rapport with patients remotely
- Will I be able to accurately assess and diagnose the patient?
- I am often worried about confidentiality or privacy breaches if the patient isn’t somewhere on their own…
- How can I be sure that patients have understood my advice and are happy with the plan?
- What do I need to document?
- My concerns are around data protection and also if patients are recording the consultation?
- I’m concerned about the ‘digital divide’ and inequality of access for some patients

Reasons for difficult remote interactions

- Patient wants to be seen face-to-face whilst clinician happy with telemedicine alone
- Clinician feels face-to-face more appropriate but inconvenient for patient to attend for f2f consultation
- Cancelled elective surgery or delayed appointments in hospital
- Disagreements over requests for referrals / investigations NB recent lack of blood bottles!



The art of diagnoses and decisions

- **Fast Thinking (System 1)**
- This system helps with the quick decisions you make and these can be life-saving. For example, if I say man in middle of street crushing at chest and then falls to floor. You think MI and you rush over and try to save him.
- Another example – rash in a dermatome on the side of a chest – you think at a glance, shingles. One more – child very unwell, floppy, has non-blanching rash = meningitis. In other words, you don't have to think too hard about it.

- Dr Daniel Kahneman (Nobel Prize winner)
- https://youtu.be/PirFrDVRBo4

- **Slow Thinking (System 2)**
- The slow system slows your thinking down and in so doing makes you make a rational and well-considered decisions. For example, a lady presents to you with chest pains – and there are bits that make you worry (e.g. going down the left arm,) but other bits that are not so worrying (sharp/burning in character).
- At first you don't know whether to refer or not. When you slow down – you think and think and think until eventually you rationally decide that because she is 67, you're not going to take the chance and so you refer her.

The approach we need is

NHS Resolution


If a relative says ***'they've never been this unwell before'***, they haven't
It's vital we listen to patients and their relatives

Managing uncertainty in primary care

- Accept that uncertainty is a normal part of primary care.
- Good clinician-patient relationship is vital.
- Involve patient in decision-making.
- Discuss probabilities including degree of uncertainty.
- Safety netting
- Consider each patient as an individual.
- Use external evidence.
- Consider use of checklist.
- Maintain good records.

Education/CPD

- Shared multi disciplinary learning can accentuate wider appreciation of another professionals skills and increased confidence in multidisciplinary working.

- Disadvantages, however, included shared learning being considered time-consuming and difficult to facilitate, with participants struggling to cover their normal workloads as well as attending the training programme

Systems in place

- Identifying urgent issues
- Audit
- SEA/Clinical Meetings
- Monitoring

Duty of candour and documentation

Duty of candour

The Nursing and Midwifery Council (NMC) **sets out a nurse's obligation in the Code to keep clear and accurate records relevant to practice**. This obligation is not limited to patient records but includes all records that are 'relevant to your scope of practice'. There is no standard documentation model across the NHS.

Supporting general practice - Medical record keeping - NHS Resolution

Keep records of all evidence and decisions - The Nursing and Midwifery Council (nmc.org.uk)

Learn From Patient Safety Events

- NHS England and NHS Improvement manage the national learn from patient safety events (LFPSE) service (previously called PSIMS)
- Centralised system to record information and offer data and analysis about patient safety events to support safety improvement across all care settings.

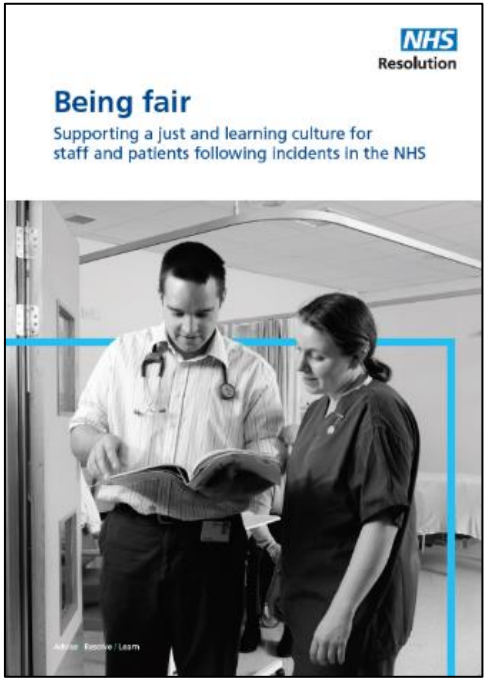
All healthcare staff in England, including those working in primary care, are encouraged to use the system to record any events where:

- a patient was harmed, or could have been harmed
- there has been a poor outcome but it is not yet clear whether an incident contributed or not
- risks to patient safety in the future have been identified
- **good care** has been delivered that could be learned from to improve patient safety.

Being fair: Just and learning culture for staff and patients following incidents in the NHS

- A just and learning culture is the balance of fairness, justice, learning – and taking responsibility for actions
- It is not about seeking to blame the individuals involved when care in the NHS goes wrong
- It is also not about an absence of responsibility and accountability

- All actions should be understood
- Staff should be supported to learn from their actions



Chaffer, D., Kline, R. and Woodward, S.

And finally: The future of General Practice

UK Parliament

Committees

UK Parliament › Business › Committees › Health and Social Care Committee ›

Formal meeting (oral evidence session): The future of General Practice

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Questions